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BMJ Open Junior doctor psychiatry placements in hospital and community settings: a phenomenological study

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ABSTRACT

Objectives The proportion of junior doctors required to complete psychiatry placements in the UK has increased, due in part to vacant training posts and psychiatry career workforce shortages, as can be seen across the world. The aim of this study was to understand the lived experience of a Foundation Year 1 junior doctor psychiatry placement and to understand how job components influence attitudes.

Design The study was conducted using a cross-sectional qualitative phenomenological approach.

Setting Hospital and community psychiatry department settings in the North East of England, UK.

Participants In total, 14 Foundation Year 1 junior doctors were interviewed including seven men and seven women aged between 23 and 34 years. The majority had completed their medical degree in the UK and were White British.

Results The lived experience of a junior doctor psychiatry placement was understood by three core themes: exposure to patient recovery, connectedness with others in the healthcare team and subjective interpretations of psychiatry. The experiences were moderated by instances of role definition, reaction to the specialty and the organisational fit of the junior doctor capacity in the specialty.

Conclusions The study reinforces and adds to the literature by identifying connectedness as being important for both job satisfaction and morale, which is currently damaged within the junior doctor population. The study provides in-depth insights into the lived experience of psychiatry placements and can be taken forward by educationalists to ensure the placements are meaningful experiences for junior doctors by developing role definition, belonging, structure and psychiatric care responsibility.

INTRODUCTION

Internationally, there is consistently low intent among medical students and junior doctors to pursue a psychiatry career.^{1–3} In the UK, despite the low fill rate of psychiatry training posts, around one in seven students express interest in psychiatry.⁴ Postgraduate work experience has been found to be one of the most important determinants of psychiatry career choice^{2 5} and attitudes can be

Strengths and limitations of this study

- This study provides a qualitative insight into the essence of the junior doctor psychiatry experience using a phenomenological approach and addresses a gap in the literature which is largely based on quantitative studies.
- The limitations of the study include the use of one UK region, some participants having prior experiences of psychiatry and the lack of triangulation across data sources.
- The purpose of phenomenology is to understand the meaning of an experience by identifying key informants rather than data saturation sampling.
- The rigour of the study was facilitated through investigator triangulation, in-depth discussion and challenging analysis, reflexivity and construct bracketing, which are all used to limit subjective researcher interpretation in qualitative studies.

influenced irrespective of prior intention.⁶ Research has shown that doctors who embark on a psychiatry career generally make this decision after graduation^{7–9} and most will make this decision within 3 years of graduating.^{2 10}

The UK Foundation Training Programme was introduced in 2005 and bridges medical school and specialty training (preregistration to registration), with six placements over 2 years. Since inception, the limited number of psychiatry Foundation Year 1 (FY1) posts has attracted those with a pre-existing psychiatry interest, with most psychiatry posts being available to Foundation Year 2 (FY2) doctors. FY1 doctors may potentially have a different experience of psychiatry than FY2, as they require more direct supervision due to their preregistration status, alongside their relatively limited postgraduate work experience. FY1 posts are critical for influencing career decisions as applications for specialty level posts occur within the first FY2 post. Recent policy changes have set the challenge to increase the number of FY1 psychiatry posts

from less than 5% of all FY1 posts to 22.5% by the end of 2017.¹¹ This presents the opportunity for more doctors to have a meaningful psychiatry experience before they make a decision about which career specialty to pursue.

There is strong evidence to suggest that the increase in FY1 psychiatry posts will have a positive association on career decisions; significantly more doctors who undertook a foundation post in psychiatry were found to progress to psychiatry training than those who did not.^{12–14} However, despite this positive influence, little is known about the actual experience of junior doctors during these placements. Furthermore, with such low numbers interested in psychiatry, it is critical that these limited opportunities to provide a psychiatry experience to junior doctors are positive meaningful experiences, even for those not interested in pursuing a psychiatry career. The current literature is mainly based on quantitative research to understand what is experienced during psychiatry placements (eg, quantifying positive/negative factors) and its impact (eg, pre-post career decisions),^{1 12} and suggests there is a strong need for in-depth qualitative research to explore exactly how the placement is experienced and how attitudes change with exposure to psychiatry.

Research questions

The study aimed to address the following questions:

- ▶ What is the lived experience of an FY1 junior doctor psychiatry placement?
- ▶ What components of FY1 psychiatry placements impact on junior doctor's attitudes towards psychiatry?

METHOD

Design

A qualitative approach was used to explore the FY1 experience by focusing on individuals' subjective interpretation of a psychiatry placement. In order to get an in-depth understanding of psychiatry placements which involve dealing with emotive mental health illnesses, we decided to use a hermeneutic phenomenology approach to fully explore the essence of the experience.¹⁵ This approach moves beyond description, and by a researcher interceding between different meanings, interpretations are made of the meanings of the experiences.^{15–17}

Data collection

The sampling strategy was purposive, and a criterion approach was used; position (FY1 doctor) and type of training rotation (psychiatry). All 16 trainees from one cohort who completed a 4-month psychiatry placement located in the North-East of England were invited to participate. The placements were spread across three different National Health Service organisation trusts and six sites. All participants took part in a one-to-one interview and completed a demographic sheet. Semistructured interviews were conducted by two senior psychiatry trainees who did not work in the same region as the FY1 doctors (see online supplementary file 1 for interview guide). Following written consent, the interviews (lasting

between 33 and 82 min) were recorded and transcribed verbatim.

Data analysis

Data analysis followed an approach developed by Van Manen which involves immersion, understanding, abstraction, synthesis, illumination, integration and critique, and finally producing the product: stories and themes.¹⁵ The analysis involved many in-depth meetings between the researchers to discuss, challenge and seek a deeper interpretation of the data. Two researchers read through all the transcripts to familiarise themselves with the data (immersion). We then coded three of the transcripts independently and discussed their interpretations of the transcripts (understanding). There were many consistencies with the coding and differences were discussed further. We then independently went through the remaining transcripts to identify what other areas emerged or challenged their early understandings of the data.

In accordance with phenomenology, we decided to focus on narratives which demonstrated emotion invoked during the placements as these were influential to attitudes (abstraction). These narratives highlighted positive and negative experiences of the placements. Aligned to the research questions, we then analysed the data to identify where job components of the role facilitated or challenged these emotional placement experiences (synthesis). This provided a basis for a secondary interpretation of the transcripts which was used to highlight consistencies and discrepancies of the job components across all of the transcripts (illumination). The preliminary findings were then considered within the context of junior doctor placements and the relevant literature (integration and critique). A final interpretation of the combination of job role factors and the emotional aspects pertaining to the lived experience of a junior doctor psychiatry placement is presented in this article (product: themes and stories).

Reflexivity

A cognisant effort was made to be aware of our own preconceptions by completing a bracketing exercise which involved recognising and putting aside (but not ignoring) previous ideas (see online supplementary file 1). This was completed early in the study to ensure focus on participants' subjective experience.¹⁸ Throughout the study, we discussed how previous experiences may influence our analytical interpretations.

RESULTS

Participants

In total, 14 FY1 doctors were interviewed including 7 men and 7 women aged between 23 and 34 years. The majority had completed their medical degree in the UK and were White British (see table 1).

Table 1 Demographic information of participants

Demographic		Frequency
Sex	Male	7
	Female	7
Age	23–25 years	12
	26–30 years	1
	>30 years	1
Ethnicity	White British	1
	White Irish	1
	Any other white	1
	Pakistani	1
	African	1
Origin of medical degree	UK	13
	Non-UK	1

The participants had FY1 experience in a range of psychiatry subspecialties during their first (n=7), second (n=5) or third (n=2) rotation (see [table 2](#)). Around half of the participants had undergraduate experience of psychiatry such as an elective or student selected component.

Themes

Three core themes emerged from the analysis which were exposure to patient recovery, connectedness with others in the healthcare team and subjective interpretations of psychiatry. These themes discuss job components of FY1 psychiatry placements associated with positive emotion, negative emotion and mediating influences on attitudes. There were some experiences which contained a mixture of these emotions, hence there are overlaps across the

themes. While each of the individuals' stories and analyses was individualistic, the forming synthesis of how individuals perceived certain components opened up new areas of understanding within each other's own lived experience ([table 3](#)).

Theme 1: exposure to patient recovery

Complex patient illness

Complex patient illnesses often mediated the perceived placement experience as feelings of frustration, relief and satisfaction were narrated with instances of patient care. Psychiatry patients were recalled to have convoluted treatment processes which could quickly revolve between being well and unwell, and a complex prognosis. This vibrant contrast was unlike many other specialities the doctors had previously experienced. Initially when assessing patients, the doctors felt 'scared' or 'shocked' as they did not know how to even begin to treat such illnesses, but this perception would later change as they later became more competent and comfortable.

'I was the one that first spoke to her and she sort of grabbed my foot and I was quite scared of her... I wasn't scared for myself it was more like I don't know what to do with this person.' (Participant 7)

'It was just pretty shocking to begin with and then it [was] quite upsetting to see because the incident happened, self-harm happened... you can't really see how he is going to get better, so it's just quite sad.' (Participant 14)

From an educational perspective, these instances provided a fascinating dissonance within the junior doctor's experiences as they referred to psychiatric

Table 2 Previous psychiatry experiences

Participant ID	Rotation number of FY1 psychiatry post (first/second/third)	Previous experience of psychiatry (outside core medical school curriculum)	Psychiatry placement type
1	First	Not disclosed	Old age
2	First	Elective and SSC	Liaison/crisis
3	First	None	Old age
4	First	None	Adult community
5	First	None	Adult inpatient
6	First	None	Adult inpatient
7	First	None	Adult inpatient
8	Second	Elective and SSC	Liaison/crisis
9	Second	Elective	Old age
10	Second	SSC	Adult inpatient
11	Second	Elective and SSC	Adult inpatient
12	Second	None	Adult inpatient
13	Third	Elective	Liaison/crisis
14	Third	None	Old age

FY1, Foundation Year 1; SSC, student selected component.

Table 3 Analytical theme development

Core theme	Experiences associated with positive emotions (eg, rewarding, enjoyment, gratification)	Mediating circumstances influencing attitudes	Experiences associated with negative emotions (eg, frustration, helplessness, isolation)
Theme 1: Exposure to patient recovery	Development of mental toughness and enhanced communication skills Feeling challenged in day-to-day role, contributing to patient care	Complex patient illness Making a difference	Lack of responsibility for patient care, unable to make a patient better Limited psychiatric skill development, menial tasks
Theme 2: Connectedness with the healthcare team	Being part of the healthcare team Supporting effective treatment plans for patients	Meaningful participation Role definition	Lack of shared experiences with peers, supervisors and patients Not being involved in decision-making processes
Theme 3: Subjective interpretations of psychiatry	Understanding the patient story Gaining valuable transferable knowledge, future career	Therapeutic value Interest in psychiatry	Stigma of profession, disengagement with patients Disinterest in psychiatry, over-reliance on pharmacology

illnesses as both 'shocking' and 'interesting'. While it was obviously unfortunate a patient was suffering from such an illness it also allowed the doctors to experience and learn about complex illnesses first-hand rather than in textbooks.

'There was a Korsakoff's psychosis; so that was completely shocking and really interesting because I've never seen that before.' (Participant 12)

'In a strange way kind of glamorises kind of psychiatry in a bizarre way...something so dramatic and exciting that can happen and so suddenly and out of the blue.' (Participant 3)

Complex patient cases often stimulated poignant memories from participants' experiences. Through these powerful experiences, the participants discussed the benefits of learning such as communication skills and developing mental toughness in dealing with helplessness of a situation.

'When you listen to their story, and then just seeing them right in front of you going from one person to the other, and then having to one day go to the aggressive person and you have to calm them down, and it improves your communication skills definitely.' (Participant 12)

'The sad thing is sort of the repeat offenders, we have one who frequently attends and he is well known to services...we all have just lost almost, and not interested and became a bit apathetic towards thinking 'How can we help this person? It's so complex... obviously things have been tried and haven't worked.' (Participant 2)

Making a difference

Experiences of patient recovery seemed to give junior doctors great satisfaction, where they could witness a change in a patient over a short period of time. Such experiences helped to enforce positive attitudes about

psychiatry placements especially when the doctors felt they made a difference in the care pathway. These poignant patient experiences were a catalyst for the way the junior doctors felt about their placements and how they could relate this information to the next patient. The junior doctors often gained value from these experiences by being involved as part of the healthcare team, and through observing the patient transition from initially being severely unwell to ultimately being discharged.

'Even those ones when they came in really unwell, families not coping and are really distressed and then when you get them back to a normal level it's great to see that transition.' (Participant 12)

'I have seen people with chronic schizophrenia... really quite unwell and it's quite disturbing to see sort of initially and then we got them to a place where they are sort of a lot more happier, a lot more settled and able to sort of integrate in the sort of community more...that's the really positive side that you do make people better, you do make improve quality of life.' (Participant 11)

Inevitably, there were some instances where patients were unable to fully recover and the junior doctors felt a degree of helplessness and sadness as they were unable to make a difference.

'As a doctor you want to make people better, and you can't make them better, and so it is just sad because they are not getting better.' (Participant 14)

'She's [patient] been ill for 30 years...thinking about that kind of old idea of people not getting better in psychiatry...that sinking feeling of this person is probably never going to get better.' (Participant 4)

There were many narratives where participants experienced making a difference in respect of treating minor medical ailments rather than psychiatric care. There

was frustration at this involvement, as they appeared to perceive they were only carrying out menial tasks.

'You do feel like you haven't got a huge role in the patient management unless something medically has gone wrong.' (Participant 14)

'I was the most medically minded of everybody in the team so I felt like it was my responsibility to take care of people's medical health so I did a lot of the general ailments.' (Participant 9)

Theme 2: connectedness with the healthcare team

Meaningful participation

The role of a psychiatry doctor is highly integrated with multidisciplinary teams providing care (eg, mental health nurses, clinical psychologists, social workers, occupational therapists). The junior doctors described working with many different professions, learning from them and having meaningful involvement.

'At the self-harm team there are nurse workers with only the Old age consultants in place and actually it's a very level playing field there and that people have got different areas of expertise...it's the first time I have truly felt I have been in a multidisciplinary team.' (Participant 9)

'I really enjoyed working with them, the staff on the ward...all working towards the same agendas and they are fun to work with...they were very grateful.' (Participant 10)

The doctors were positive and enthusiastic about the interactions they had with others in the team when they felt supported and encouraged by others, depicting a lack of social isolation.

'You feel supported, you don't feel out on your own which is the one of the main things I was scared about.' (Participant 2)

'I loved the team, it was an incredible team to work in. Every day you meet the occupational therapists you get to give your input. Social workers, the nurses were so knowledgeable with mental health...the Consultants, were really supportive, I thought it was a wonderful team.' (Participant 9)

Acute patient care experiences provided key insights into how the psychiatry department worked as a team under difficult circumstances. Involvement in such challenging situations had a positive influence on their attitude as it led to them feeling part of the team. In other less acute situations, there was often a lack of shared experiences across the professions and a perceived lack of participation in the team.

'She'd taken an overdose over the weekend, and that was a really horrible introduction to psychiatry but actually it showed that a team comes together and everyone supported each other through it.' (Participant 9)

'My role was a bit supernumerary to be honest...you clerk in new patients, you sort out any medical problems, you obviously look after the cardexs but everything else is done by the FY2 or seniors.' (Participant 12)

Role definition

The role definition of the FY1 post provided interesting narratives as participants often perceived having a clinical (non-psychiatry role) within the psychiatry placement. This role enabled them to have involvement in supporting effective treatment plans. Participants described experiences where they built up rapport with patients and were able to reassure them.

'The patient sort of just sat down next to me and said 'oh I'm glad you're here' and that he had someone to act as like an advocate and that I could cos I think it was quite an important aspect of his care.' (Participant 2)

'I had a good sort of rapport with him...he had some persecutory beliefs about some of the other members of the team so because I had a super rapport with him that was used quite a lot through his stay.' (Participant 11)

In respect of psychiatric care, there were times when the participants felt a lack of connectedness with others because they had little input into patient care. They were frustrated with the limited opportunities set by their role within the healthcare team.

'It's basically like a GP for the hypochondriacal, is basically the best way to describe it...you have to go through the whole history and examination for something that they otherwise wouldn't have went and seen a doctor about.' (Participant 5)

'You have less responsibility... you haven't a huge amount of input in the psychiatric management, your role is much more like a medical management, like medical ailments, like something like a GP [General practitioner] on a psychiatric ward.' (Participant 14)

Ultimately, the decisions that were made about a patient's healthcare were primarily by the seniors and consultants. Subsequently, the junior doctors perceived having very little responsibility and were, at times, unsure of their role within the team. This provoked frustration in respect of their limited learning opportunities. This frustration with their role was often underpinned by the level of control in terms of patient care and autonomy and fostered negative attitudes towards future involvement in patient care.

'Unclear really where my role fits in from a psychiatry point of view...there are some situations where you feel maybe that you want to kind of mention something that you have noticed but you are not really sure that it's kind of that's your role.' (Participant 3)

'The consultant would make all of the decisions and

then I would look after them [patients] all in the meanwhile...Sometimes, it felt frustrating that I felt like I knew the patients better from having observed them all day, every day, but they are the experts.' (Participant 9)

Theme 3: subjective interpretations of psychiatry Therapeutic value of doctor–patient relationships

The recognition of the importance of relationships between doctors and patients adding therapeutic value to care varied among the participants. Some participants happily engaged in befriending patients and discussing aspects external to the healthcare role. They saw value in the time invested in understanding the patient journey and saw its importance in building rapport with patients.

'Interactions with some of the patients can be really nice, like rewarding, and also really funny at times, like especially cos you get to know them obviously more and they have a longer inpatient stay.' (Participant 10)

'I was proud that I knew everybody on the ward, I knew them inside out, I knew their meds, I knew their family, I knew what they liked every day, I spoke to the nurse about them every day.' (Participant 9)

In contrast, some of the junior doctors felt this befriending type of interactions with patients added little clinical value to their learning and the treatment process. This led to more negative emotions such as those associated with a poor use of time and not furthering the development of skills. The lack of value of patient relationships to care invoked a broader frustration at the stigma of psychiatry. Participants felt frustrated about the stigma associated with patients in psychiatry and the communication with other medical departments.

'You don't want to spend your day listening to people, like a hypochondria talk about their problems.' (Participant 14)

'It really annoys me when people have got a diagnosis and they are an inpatient in a psychiatric hospital that's a label that they get stuck with and you can't have arguments with medical teams because they don't really want to keep the patient.' (Participant 9)

Interest in psychiatry

The level of interest in psychiatry as a discipline appeared to guide what the doctors gathered from the experience and how they experienced challenging situations. The resilience of the junior doctors was highlighted when dealing with difficult situations. The subjective attitude that the doctors had towards psychiatry enabled them to see strengths and weaknesses in the logistical aspects of the placements. The placements perhaps facilitated more time than other specialities for junior doctors to have more time to reflect and learn about the clinical material.

'People who work in psychiatry they do need to be quite brave and make kind of bold decisions, and

obviously like the patient who we saw in the crisis team setting sometimes having to go down the route of a Mental Health Act and these aren't easy decisions.' (Participant 13)

'I think it's made me a lot more aware of kind of people with psychiatric problems...before I would want to sort of not really sort of understand that.' (Participant 3)

Often participants discussed the positive work life balance afforded by psychiatry placements. They acknowledged that psychiatry was different from other specialties and more like a traditional 9–5 working role.

'Overall I have enjoyed it. It was really nice environment to work in, it's really nice having like a 9–5 kind of job that's kind of not too stressful and I have felt like I am in control of the situation.' (Participant 3)

'It gives you a lot more opportunity to learn on the job than other rotations. So on medical wards you might see something extremely interesting but you are either too rushed or too tired when you get home to bother to read about it.' (Participant 14)

The placements enabled the doctors to have more of an informed opinion about whether they wanted to work in psychiatry in the future. Even for those who were not encouraged they felt the placement provided them with skills that they could use in other specialties.

'When you're with a patient and in particular a depressed patient...you feel emotionally drained at the end of it so I don't know if I could cope with doing that all day for the rest of my life.' (Participant 10)

'I have found it really useful when I have done sort of on-calls in the hospital at weekends and they have sort of patients with psychiatric problems...nurses and other doctors just sort of panic at it.... I am quite calm when I get a patient like that.' (Participant 7)

DISCUSSION

Findings in context

The FY1 psychiatry experience was understood by three core themes involving exposure to patient recovery, connectedness with others and subjective interpretations of psychiatry. The lived experience of a psychiatry placement has resonance with belongingness; belonging to the discipline, belonging to the healthcare team and belonging to making a difference to patient care.

In the current study, exposure to patient recovery enabled the doctors to gain an experience of psychiatry that was often initially challenging but then later brought great rewards as they witnessed a powerful contrast in the patient journey. The instance in which this was particularly apparent was for those who had experiences in old age psychiatry, perhaps due to building up rapport

with such patients over time. This theme supports other research which has found witnessing patient recovery as one of the most positive experiences of a psychiatry placement.³

The connectedness with others in the healthcare team was pivotal in junior doctors' understanding their role boundaries. There were encouraging and supportive relationships between the doctors and other members of the healthcare team. However, the doctors were sometimes unsure of their professional capacity within the placements, as they sometimes felt they did not belong as psychiatrists or junior doctors. This lack of belonging may have negated the positive experiences within the clinical healthcare team. The Royal College of Physicians has recently published a paper on 'Keeping Medicine Brilliant' which identifies 'relatedness' to impact on morale and job satisfaction which then encourages individuals into a profession.¹¹ This applies to all aspects of a career in Medicine, and it is perhaps a key marker of a good placement and could be considered as a metric when evaluating placements through quality processes.

Psychiatry involves a collaborative multidisciplinary team which may have blurred the role definition experienced by the participants. The mental health nurses often had more specialised knowledge of psychiatry treatment pathways than the junior doctors themselves. The FY1 doctors therefore were exposed to a role defined by their current circumstance rather than what a potential senior psychiatry career may entail. Similarly, in the current study, it has been found that when junior doctors encounter complex psychiatric patient cases, their experiences of working in effective healthcare teams can mediate beneficial learning effects.¹⁹

Finally, subjective interpretations involved the constitution of what psychiatry meant to the doctors and how they engaged in their placements. The doctors who had more powerful experiences tended to be those who sought learning opportunities and pursued their own interests. Moreover, psychiatry as a discipline was often seen to be stigmatised and as such this may have an impact on those who are to overcome such barriers within Medicine.²⁰

The job components of FY1 psychiatry placements need to be addressed in order to maximise potential learning opportunities. Research into psychiatry leavers shows that job dissatisfaction and stress feature highly among the reasons for attrition.^{7 21} Specialty switching is not unique to psychiatry but where quality of life is the most common reason in other specialties, the reason in psychiatry is job satisfaction.²² A study which investigated procedural and organisation factors demonstrated issues such as isolation, supervision and induction as prominent in 'unpopular' placements.²³ While in the current study, isolation was not explicitly identified in participants' experiences, there were concerns over role definition in the workplace which formalised induction could address.

Study strengths and limitations

This study provides a qualitative in-depth insight into the essence of the FY1 psychiatry experience and addresses a gap in the literature which is largely based on quantitative studies. The rigour of the study was facilitated through investigator triangulation, in-depth discussion and challenging analysis, and construct bracketing, which are all used to limit subjective researcher interpretation in qualitative studies.^{17 24 25}

The limitations of the study include the use of one region, previous psychiatry experiences of some participants and the lack of triangulation of data sources. The participants worked in a range of psychiatry healthcare settings and are not believed to be atypical of psychiatry placement settings across the UK. Many of the participants had prior experiences of psychiatry, therefore the study cannot fully consider the impact of the placements on those who have low or no interest in psychiatry. However, 14 of a possible 16 doctors were interviewed. Data saturation was not part of the sampling strategy approach as the purpose of phenomenology is to look for the meaning and significance of a phenomenon by identifying key informants.¹⁵ Therefore, the sample size was believed to be sufficient as we answered the research questions.

What does this study add?

Internationally, there is a shortage of psychiatry doctors and recent policy changes in the UK have increased the number of psychiatry placements that are being provided.¹¹ This increase in number offers an exciting yet challenging time for medical educators as there is limited understanding of how these placements are experienced. This study has delved deeply into the experience of the psychiatry placements and contributes to the literature in three ways.

First, the study identifies the lived experience of a junior doctor psychiatry placement. The placement experiences were understood by exposure to patient recovery, connectedness with others and subjective interpretations of psychiatry. Junior doctors are faced with many challenging issues during their placements but their participation within the healthcare team is integral to what developments in their learning they take forward from the placements. These findings are relevant to overall perceptions of psychiatry for junior doctors, even if they do not go on to specialise in psychiatry. As mentioned in the results, better understandings of mental health issues gained through foundation year psychiatry experiences may enhance the practice of doctors who go on to work in other areas outside of psychiatry.

Second, the study allows educators to further develop an understanding of the job components of junior doctor psychiatry placements, and how to adapt these. Lessons are available from other specialties that could be usefully considered together. The analysis highlights the importance of involving doctors in psychiatric patient care, integrating them within the healthcare team and adapting their experiences aligned to their interests.

Third, the study provides insight into the role of a junior doctor in terms of the role definition, belonging, structure and responsibility. This may help guide the development of specific questions to be asked at quality monitoring visits with regard to the value of a placement and assess the impact on morale. Junior doctors are at key stage in their development and informing career decisions, therefore the learning environment should be given further consideration in order to maximise the benefits of the placements. It is key that team structures are facilitative for junior doctors to adopt meaningful roles in the healthcare team.

Further research

This research has focused specifically on doctors; however, further research is needed to investigate experiences of the rest of the clinical team to understand the wider impact of the increased number of placements. Moreover, there is a need to further investigate the differentiation of psychiatry placement experiences by prior experience and interest level. The uptake of those interested in psychiatry is likely to have a significant impact on the findings, therefore there is a need to further understand the experiences of those who were not keen to take a psychiatry placement.

CONCLUSIONS

The lived experience of a junior doctor psychiatry placement involves many interactions with patients, the healthcare team and supervisors which collectively influence attitude, belongingness and ultimately the placement experience. The FY1 psychiatry experience was understood by three core themes of exposure to patient recovery, connectedness with others and subjective interpretations of psychiatry. This study provides in-depth qualitative insights at a crucial time when little is known about how psychiatry placements are experienced. The findings can be taken forward in the development of junior doctor placements by developing role definition, belonging, structure and psychiatric care responsibility to maximise the educational value of these opportunities.

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Contributors PESC made a substantial contribution to the analysis and interpretation of the data, and writing of the manuscript. SB made a substantial contribution to the conception and design of the study, acquisition of data, analysis and interpretation, and editing and revising the manuscript. CS made a substantial contribution to the conception and design of the study and acquisition of data, and revising the manuscript. NK made a substantial contribution to the design of the study, acquisition of data, and revising the manuscript. PLC made a substantial contribution to the conception of the work and design of the study, and revising the manuscript. In addition, all authors agree to be accountable for all aspects of the work and gave final approval of the version to be published.

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Competing interests None declared.

Ethics approval Research and development approval for study was granted by the organisations involved and ethical procedures were followed at all times. This study was deemed exempt from NHS ethical review as the study involved qualitative interviews with NHS staff. Participants were given information sheets, written consent was taken prior to taking part in the study, and participant anonymity was protected.

Provenance and peer review Not commissioned; externally peer reviewed.

Data sharing statement We do not have ethics approval to make raw data from this study available for sharing.

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REFERENCES

1. Farooq K, Lydall GJ, Malik A, et al. ISOSCCIP Group. Why medical students choose psychiatry - a 20 country cross-sectional survey. *BMC Med Educ* 2014;14:1.
2. Goldacre MJ, Turner G, Fazel S, et al. Career choices for psychiatry: national surveys of graduates of 1974-2000 from UK medical schools. *Br J Psychiatry* 2005;186:158-64.
3. Karageorge A, Llewellyn A, Nash L, et al. Psychiatry training experiences: a narrative synthesis. *Australas Psychiatry* 2016;24:308-12.
4. Budd S, Kelley R, Day R, et al. Student attitudes to psychiatry and their clinical placements. *Med Teach* 2011;33:e586-e592.
5. Maidment R, Livingston G, Katona C, et al. Change in attitudes to psychiatry and intention to pursue psychiatry as a career in newly qualified doctors: a follow-up of two cohorts of medical students. *Med Teach* 2004;26:565-9.
6. McParland M, Noble LM, Livingston G, et al. The effect of a psychiatric attachment on students' attitudes to and intention to pursue psychiatry as a career. *Med Educ* 2003;37:447-54.
7. Moloney J, MacDonald J. Psychiatric training in New Zealand. *Aust N Z J Psychiatry* 2000;34:146-53.
8. Brown TM, Addie K, Eagles JM. Recruitment into psychiatry: views of consultants in Scotland. *Psychiatr Bull* 2007;31:411-3.
9. Dein K, Livingston G, Bench C. 'Why did I become a psychiatrist?': survey of consultant psychiatrists. *Psychiatr Bull* 2007;31:227-30.
10. Mahoney R, Katona C, McParland M, et al. Shortage specialties: changes in career intentions from medical student to newly qualified doctor. *Med Teach* 2004;26:650-4.
11. Royal College of Physicians. Keeping medicine brilliant: Improving working conditions in the acute setting, 2016. <https://www.rcplondon.ac.uk/guidelines-policy/keeping-medicine-brilliant> (accessed 17 Jan 2017).
12. Kelley TA, Brown J, Carney S. Foundation programme psychiatry placement and doctors' decision to pursue a career in psychiatry. *Psychiatrist* 2013;37:30-2.
13. Kuhnigk O, Hofmann M, Böthner AM, et al. Influence of educational programs on attitudes of medical students towards psychiatry: effects of psychiatric experience, gender, and personality dimensions. *Med Teach* 2009;31:e303-e310.
14. Prasad SJ, Nair P, Gadhi K, et al. Improving the quality of psychiatry teaching within the UK undergraduate medical curriculum. *Adv Med Educ Pract* 2016;7:163.
15. Van Manen M. *Researching lived experience: human science for an action sensitive pedagogy*. California: Left Coast Press, 2015.
16. Lopez KA, Willis DG. Descriptive versus interpretive phenomenology: their contributions to nursing knowledge. *Qual Health Res* 2004;14:726-35.
17. Creswell JW. *Qualitative inquiry and research design: choosing among five approaches*: Sage, 2012.
18. Starks H, Trinidad SB. Choose your method: a comparison of phenomenology, discourse analysis, and grounded theory. *Qual Health Res* 2007;17:1372-80.
19. Nash L, Karageorge A, Llewellyn A, et al. Accentuate the positives, but don't necessarily eliminate the negatives: a cross-sectional survey of junior doctor psychiatry terms. *MedEdPublish* 2016;5.

20. Boyle A, Davies S, Dogra N, *et al.* The foundation programme in psychiatry: a qualitative study into the effects of a foundation placement. *BJPsych Bull* 2016;40:281–4.
21. Lambert TW, Turner G, Fazel S, *et al.* Reasons why some UK medical graduates who initially choose psychiatry do not pursue it as a long-term career. *Psychol Med* 2006;36:679–84.
22. Lambert TW, Davidson JM, Evans J, *et al.* Doctors' reasons for rejecting initial choices of specialties as long-term careers. *Med Educ* 2003;37:312–8.
23. Welch J, Bridge C, Firth D, *et al.* Improving psychiatry training in the foundation programme. *Psychiatrist* 2011;35:389–93.
24. Fielden JM. Grief as a transformative experience: weaving through different lifeworlds after a loved one has completed suicide. *Int J Ment Health Nurs* 2003;12:74–85.
25. Pope C, Ziebland S, Mays N, *et al.* Analysing qualitative data. *BMJ* 2000;320:114–6.